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Reform of Primary Health Care in Kazakhstan and the Effects on Primary Health Care Worker Motivation: The Case of Zhezkazgan Region

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Partnerships
for Health
Reform

PHR

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Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *better informed and more participatory policy processes in health sector reform;*
- *more equitable and sustainable health financing systems;*
- *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

This paper reports the experiences of primary care reform in the Zhezkazgan region of Kazakhstan. After the collapse of the Soviet regime, Kazakhstan undertook a radical program of reform to restructure the health sector, making primary care the centerpiece of their health reform agenda. The reforms included the creation of independent family group practices financed on a capitation basis directly from the Ministry of Health, allowing free choice of primary care providers through open enrollment, and creating a non-governmental primary care physician association. This program has had remarkable success in improving motivation among primary health care workers. Part of this success can be explained by the multiple strategies adopted, including communicating and preparing providers and communities for changes, providing stronger financial incentives for performance, ensuring strong feedback mechanisms from the community to care providers, and engendering a stronger sense of professionalism among primary care providers. The paper describes how changes in the overall organizational relationships and economic incentives have led to increased interest in primary care among physicians, increased attention to quality and patient satisfaction, more rational and creative use of resources, and stronger commitment of physicians' personal time and resources to improve services for patients.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CIS	Commonwealth of Independent States
FAP	Primary Care Outposts
FGP	Family Group Practice
GDP	Gross Domestic Product
MHI	Mandatory Health Insurance
MOH	Ministry of Health
NEM	New Economic Mechanisms
PHR	Partnerships for Health Reform
SVA	Primary Care Clinic
USAID	United States Agency for International Development

Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance "knowledge and methodologies to develop, implement, and monitor health reforms and their impact. This goal is addressed not only through PHR's technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities.

The research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

- Analysis of the process of health financing reform
- The impact of alternative provider payment systems
- Expanded coverage of priority services through the private sector
- Equity of health sector revenue generation and allocation patterns
- Impact of health sector reform on public sector health worker motivation
- Decentralization: local level priority setting and allocation

Each major research project comprises multi-country studies. Such cross-country comparisons will cast light on the appropriateness and success of different reform strategies and policies in varying country contexts.

These working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work emanating from the Applied Research program. The final reports will be disseminated by PHR Resource Center and via the PHR website.

Sara Bennett, Ph.D.
Director, Applied Research Program
Partnerships for Health Reform

1. Introduction

In Kazakhstan, as in other countries of Central Asia, a health reform movement is underway that is specifically aimed at strengthening primary care to reduce the inefficiencies in the health care system and to improve the overall quality of health care. After decades of emphasis on non-integrated specialized health care under the Soviet system, the primary care sector was left with personnel who were the most poorly trained, most underpaid, and least professionally autonomous health care providers in the system. It is not surprising that health workers in the primary care sector seemed unmotivated to increase their productivity or to improve their performance.

The legacy of the Soviet system and the turbulent transition to a market-based economy have had dramatic consequences for the health sector in all of the countries of the former Soviet Union, and the primary care sector has borne a disproportionate share of the burden. Resources available for health care in Kazakhstan have declined steadily since the 1980s, with health care expenditures as a percentage of gross domestic product (GDP) declining from about 6 percent in the 1980s to less than 3 percent in 1995. In addition, GDP continued to fall over that period,[1] resulting in a significant reduction in real per capita health expenditure. It is estimated that real per capita public health spending in 1994 (approximately $15) was only 40 percent of the pre-transition level.[2]

In addition to chronic underfinancing, the health care systems of the former Soviet republics suffer from profound inefficiency. One of the greatest inefficiencies in these systems is the imbalance between hospital and outpatient, particularly primary, care. In Kazakhstan, hospitals received more than 76 percent of government health care expenditures in 1996. The perpetuation of this imbalance over time has reduced the capacity of the primary care sector to provide adequate services to the population, causing primary care physicians to refer simple cases to specialists and hospitals, or patients to bypass primary care completely and refer themselves directly to hospitals. Under the current financing mechanism that allocates budgets according to a combination of capacity and utilization, the bypassing of primary care results in further reductions in financing for the sector.

The government of Kazakhstan long ago acknowledged the need for health care reform. The earliest reform activities began before independence from the Soviet Union, with the establishment of five health reform demonstration sites in Kazakhstan under the New Economic Mechanisms (NEM) in 1989. Although the NEM demonstration sites in Kazakhstan were canceled in 1990, some of the general principles of reform had already taken root. In 1992, the new government of independent Kazakhstan established three oblasts as new health sector demonstration sites (Zhezkazgan, South Kazakhstan, and Kokchetau). Under the demonstration program, one area of the former Zhezkazgan oblast, began a health insurance experiment in 1993.

To establish an alternative source of financing for the health sector, the President of Kazakhstan extended the health insurance experiment nationwide by a decree in June 1995, which guaranteed medical insurance for all citizens of Kazakhstan. In addition to introducing health insurance to increase or diversify financing for the health sector, the Ministry of Education, Culture and Health[3] has also had the explicit policy of improving the efficiency of the health care system by rationalizing the hospital sector, privatizing selected health care facilities, and developing a strong system of primary care.

[1] It is estimated that Kazakhstan's GDP in 1996 was only 46 percent of the level of 1989 (Kaser 1997).

[2] Unpublished World Bank document

[3] In 1997, the President of Kazakhstan reorganized the government ministry structure and merged the Ministries of Education, Culture and Health into one ministry. The former Minister of Health became the Chairman of the Committee on Health within the new ministry.

Where the government's health reform strategy has been implemented at the local level, it has led to significant changes in the organizational structure of primary health care, the degree of clinical and managerial autonomy of primary care providers, the financial incentives faced by personnel in the primary health care system, and the population's level of involvement. The impact of these reforms on the motivation of primary health care providers has been variable. In some sites, primary care providers have clearly demonstrated a new level of motivation and professionalism that has had a visible impact on the communities they serve. In other sites, the impact of the health reform strategy on primary health care worker motivation has been less clear. This paper describes the primary health care reform strategy in the former Zhezkazgan oblast,[4] the site that has exhibited the most dramatic change in the level of motivation of primary health care workers, and draw some conclusions about those elements of Zhezkazgan's reform package that had the greatest impact on improving health worker motivation and performance.

[4] An oblast is an administrative region roughly equivalent to a state in the United States.

2. Work Culture and Motivation Prior to Reforms

The level of motivation of the public health care labor force in Kazakhstan prior to the introduction of health care reforms was shaped by two important factors: the incentives inherent in the organization, financing and management of the former Soviet health care system, and the devastating financial crisis that followed the collapse of the Soviet Union.

2.1 Organization of the Delivery System Under the Soviet System

Prior to the introduction of health reform, the health care system in Kazakhstan followed the typical Soviet model. Physical and economic access to primary care was a high priority, and an elaborate network of primary care facilities existed that reached even the most remote rural areas. The quality of primary care deteriorated over time, however, because the financial and administrative position of primary care was subordinate in every way to specialty care. Primary care was under the administrative, financial and clinical control of specialty-oriented polyclinics and hospitals.

Primary care in urban areas was provided through polyclinics, which employed a wide range of narrow specialists, as well as primary care physicians (catchment physicians). There were three polyclinics in each administrative region of each city, one for adults, children, and women's reproductive health services (women's consultation centers). Therefore, there were different primary care physicians for adults, children and reproductive health services. Primary care physicians were trained either as adult therapists, pediatricians or gynecologists.

This dispersion of primary care inhibited providers from taking a broader interest in their patients and from providing integrated, family-oriented care.[5] Different physicians treated different members of one family, which did not allow physicians to have complete information about their patients or opportunities to examine or counsel several members of the family during a single visit. The structure of the urban health care system prevented primary care physicians from becoming true general practitioners, or family doctors, which deprived them of a clearly defined role in the health care system.

The health care system in the rural regions (rayons) presently revolves around the central rayon hospital, located in a semi-urban rayon center. The central rayon hospital serves both clinical and government administrative functions. The hospital is the locus of power and decisionmaking for the allocation of all rayon health resources, management and personnel issues, and clinical oversight in the region. The central rayon hospital includes an attached outpatient specialty polyclinic that serves as an outpatient referral center for the entire rayon. The polyclinic includes a primary care department that serves the residents of the rayon center. The rayon is divided into catchment areas, each served by a primary care clinic, known by the Russian acronym, SVA. The SVA, which in Kazakhstan typically serves between 1,000 and 3,000 people, is staffed by a physician, nurses, a midwife and non-medical personnel. The SVA's catchment area is further subdivided into areas served by primary care outposts known as FAPs, which are staffed by feldshers (physician's assistants) and midwives.

[5] " The Missing Generalist," p. 72-90 in Ryan 1990.

SVA physicians are trained either as adult therapists or as pediatricians, but must serve everyone located in their catchment area. In addition, because of the low population density in rural Kazakhstan and long travel distances from villages to rayon centers, SVA physicians often provide a wider range of services than their urban counterparts. Therefore, although they are also trained as narrow specialists, rural primary care physicians are more likely than urban physicians to function as true family doctors.

2.2 Financing of Primary Care Under the Soviet System

The financing of the health sector in Kazakhstan followed the Soviet practice of paying health facilities through yearly guaranteed budgets. The annual budgets were based on the planned capacity of the facility, which for a polyclinic or SVA equaled the potential number of patient visits in a year. The capacity of an outpatient facility was determined by the number of employees and size of the building. Under the budget system, the planned capacity served as an output target for the facility. If the output target was not met, the facility's capacity, and therefore the budget, were reduced in the following year. Conversely, if the output target was exceeded, the facility's capacity and budget were expanded. Financing was in no way linked to the value of the services provided or the satisfaction of the consumers served.

Under the former system, primary care facilities had virtually no control over their financial resources. Because primary care facilities were not recognized as independent legal entities, primary care providers were not entitled to maintain their own bank accounts. Therefore, primary care budgets were managed by polyclinics and hospitals. Funds had to be disbursed according to nationally regulated percentage allocations across budget line items, and polyclinics and hospitals decided how the aggregate pool of funds would be allocated between inpatient and outpatient care. Under this resource allocation system, primary health care typically received less than 15 percent of overall health care budgets.

The budget process also created incentives for the polyclinics and hospitals to increase the number of services provided in order to increase their capacity and budgets. Buildings and personnel were added at all levels, but the funds that followed stayed in the polyclinics and hospitals, and were not distributed to primary care facilities. Presently, after decades of this financing cycle, the primary care sector has enormous, underutilized buildings and staffs, which consume all of their resources. The central budget authorities have eliminated nearly all categories of primary care clinic budgets, except salaries and utilities to support the massive physical capacity. Without funds for medicine and supplies, these barren structures have extremely limited capacity to provide clinical services to their patients.

Under the former system, salaries of health care workers were strictly controlled by a national salary schedule that linked salaries to type of position, educational level, and years of experience. Health worker compensation was completely independent of performance. Physicians who worked well were paid the same salary as those who were less productive and less attentive to their patients. The only way to increase a health worker's salary was to allow that person to fill more than one position, at least on paper. These additional positions were rarely awarded according to merit, but rather through personal relationships or in exchange for favors. Health care workers, therefore, had no economic incentive to improve their performance, to increase the satisfaction of their patients, or to acquire new knowledge and skills.

Relative to other physicians, primary care physicians were not the lowest on the government pay scale. In the 1970s, the health care salary structure was altered to encourage physicians to enter primary care, and by adding a 20 percent premium to the salary of polyclinic catchment physicians. There was a separate premium added to the salary of rural health care workers, who also received other financial and in-kind benefits to compensate them for the hardship of their post. Although their

formal salary was not the lowest in the system, however, primary care physicians had the least opportunity to supplement their income. It was almost always more lucrative to work as a specialist, because specialists were able to supplement their salaries with unofficial side payments, or by working night shifts in hospitals. Primary care physicians did not typically receive unofficial side payments, however, because the work of a primary care physician was viewed as humanitarian work, and side payments were unacceptable to both patients and primary care physicians.

2.3 Relationship of Primary Care Providers to the Population

Under the Soviet system, health care workers were not accountable in any way to the population. Individuals did not have the right to choose their health care provider and had little recourse for poor service. Each person was assigned to a facility and a catchment physician according to residence, which was documented in his passport. In addition, individuals did not have access to information about their own health care, and they were often reluctant to ask questions or make complaints about the specific services they received. These circumstances resulted in a lack of power for patients in the doctor-patient relationship, and a lack of responsiveness on the part of primary care physicians to the comfort and satisfaction of the patients.

2.4 Management Structure and Style

The hierarchy and management style of the health care sector under the former Soviet system probably had the most severe negative impact on the motivation of primary health care workers. The health care system was managed in the spirit of Soviet hierarchy: subordination to authority, and elaborate bureaucratic control of day-to-day professional activity. Performance incentives and evaluation criteria centered on strictly enforced norms for the practice of medicine, and quantitative output targets for the number and type of services provided.

The administrative structure of polyclinics included a head physician, a deputy, and heads of clinical departments. Rural SVAs were administered by a head physician, who was under the direct clinical and administrative supervision of the head doctor of the Central Rayon Hospital. The SVA head doctors did enjoy slightly more managerial autonomy, however, than urban primary care physicians because most SVAs are physically located quite far from the rayon administrative center.

All health facility administrators were physicians who, unlike their counterparts in the education sector, did not receive any supplemental management training,[6] even though they spent nearly all of their time on administrative work, and virtually no time practicing medicine. Thus, they rarely understood the principles of human resources management and how to support and motivate their staffs. Head physicians had total, virtually absolute authority over their subordinates, and ultimately made or strongly influenced nearly all decisions in the health facility. They typically provided only negative feedback, which was acceptable, even expected, in the Soviet work culture and environment.

Although negative feedback and punishments were more common than acknowledgment and praise, there was no real threat of job loss for poor performance. Most physicians received their positions through personal connections and other non-competitive means, and, thus, had nearly complete job security. It was extremely difficult to dismiss any employees under Soviet labor laws.

The administrative controls over health care service delivery and the criteria used to evaluate health provider performance greatly inhibited professional motivation. Services available at primary care clinics and how they were provided were tightly controlled by the central government. Clinical

[6] "Doctors and Administration," p. 110-127 in Ryan 1990.

practices, such as referrals and the length of a primary care visit, were controlled by MOH normatives, and health care worker performance was judged against these normatives. Health workers, therefore, had little opportunity to develop and exercise clinical judgment, or to find innovative solutions to clinical and organizational problems.

Information in the former system was used to monitor the level of achievement of normatives and output targets, and to provide aggregate statistics at the national level. Information was typically used for the purposes of control rather than for useful feedback to improve performance. Physicians were overburdened by paperwork, and spent much of their time ensuring that forms were completed properly in order to avoid punishment. Health care workers were evaluated almost exclusively according to written documentation, including patient charts and government statistical forms. Health care workers, therefore, had greater incentive to complete their reports in such a way as to show that they were complying with the normatives and meeting output targets than to actually provide high quality care to patients.

The tight administrative controls combined with the depletion of resources resulted in a deprofessionalized and unmotivated primary health care labor force that found it easier and to simply refer patients to a higher level facility than to treat them. As noted by Dr. Yevgeni Chazov, Minister of Health of the Soviet Union during the period of *perestroika* under President Mikhail Gorbachev, primary health care providers evolved into disinterested dispatchers in the health care system.[7]

2.5 The Current Financial Crisis

Finally, the financial crisis that has rippled through Kazakhstan's social sector since the collapse of the Soviet Union has had a devastating effect on the morale and commitment of health care workers. The transition to a market economy and the government budget crisis has put an end to the principle of free health care under the Soviet model, and the humanitarian principal upon which most health care workers entered the medical profession has been violated.

The main positive source of motivation for health care workers under the former system was the high social status and respect accorded physicians because of the humanitarian nature of their work. Health care workers, particularly physicians, were considered to be well educated and distinguished members of society, providing an altruistic service to the population. The transition to a market economy and the financial crisis, however, have nearly eliminated the humanitarian nature of physicians' work, and has made the high social status of physicians less important than their relatively low economic status. Informal side payments and outright bribery for health care services have become nearly universal.[8] In addition, patients must search for and pay out-of-pocket for nearly all drugs, and personally supply or pay for basic supplies in the hospital, including syringes, food, bed linen, and other staples.

As employees of what was designated a "non-productive" sector during the Soviet period, health care workers are paid substantially less than unskilled workers in "productive" sectors, such as industry and manufacturing. At an average of less than $150 per month, physicians are paid less than the average salary for all government workers in Kazakhstan, and substantially less than almost any private sector employee.[9] Respect and social prestige no longer compensate physicians for their economically disadvantaged position now that they have to survive in a more market-oriented

[7] "Nashi plany diktuet vremya," s.1. in Shcheglov 1987.

[8] Although the magnitude of informal side payments is empirically difficult to estimate, Ensor and Savelyeva analyze existing evidence and conclude that such revenues may amount to approximately 30 percent of the government health care budget.

[9] Ministry of Finance estimates in a World Bank unpublished document. This imbalance has, however, been improving over time. In 1993, physicians received approximately 54.6 percent of the economy-wide average wage, whereas in 1997 they received approximately 83.5 percent.

economy. Furthermore, health care workers often wait long periods without receiving salaries. The situation has generated a sense of insecurity among health care personnel. Many physicians in urban areas, where there are employment opportunities in the formal and informal sectors, are leaving the medical profession for more highly paid work, even taking positions of extremely low social status, such as paid child care or housekeeping, to support their families.

The effect of the financial crisis on the health status of the population has also demoralized health care workers. The life expectancy in Kazakhstan declined by 4.7 years between 1991 and 1996 to 64.9 years. The life expectancy gap between males and females increased from 5.8 to 10.4 years over the same period.[10] In addition, the general mortality rate in the country has increased, while the birth rate continues to fall. In two oblasts, Karaganda and East Kazakhstan, the situation has led to a negative population growth rate, with other oblasts expected to soon follow that trend. The deterioration of drinking water quality has led to a drastic increase in the spread of infectious diseases such as diarrheal disease and hepatitis. The tuberculosis morbidity rate in the country has reached epidemic levels (91.3 cases/100,000 population). In addition, previously eradicated diseases, such as diphtheria and scabies, have reappeared, and sexually transmitted diseases have spread at an alarming rate. For example, Acquired Immune Deficiency Syndrome (AIDS) morbidity has increased significantly, and the number of syphilis cases has increased more than one hundred times in the last seven years.

The result of the health care crisis has been a collapse in the public's trust and confidence in the health care system, and in health care workers themselves. There is evidence that people are increasingly choosing to bypass the formal health care system altogether and turn instead to self-treatment or traditional healers. It is likely that the motivation of health care workers and their enthusiasm for their profession was at an all-time low prior to the initiation of the health reform program in Kazakhstan.

[10] United Nations Development Programme/Kazakhstan. 1997.

3. Description of the Reform Program

The former Zhezkazgan oblast[11] has the most advanced health reform program in Kazakhstan. As one of the earliest health reform sites in the Soviet Union, Zhezkazgan has a history of bold experimentation and innovation in the health sector. After six years of small-scale reform experiments, Zhezkazgan was the first oblast in Kazakhstan to establish an oblast-wide mandatory health insurance system in 1995. Local leadership seized the opportunity to use the new insurance system as a catalyst for comprehensive reform of health financing and service delivery.

The national policy context in which the Zhezkazgan health sector reforms were initiated was one of mixed support for and suspicion of reforms (this will be addressed in greater detail in section 5). The national government had embarked on a relatively aggressive policy of privatization and decentralization even before Kazakhstan became an independent republic.[12] There was, therefore, growing acceptance of market relations and entrepreneurial activity in the economy in general at the time the Zhezkazgan reforms began. As noted by Kaser, however, rapid privatization following the collapse of the Soviet Union took place in the absence of public experience with a market system, and the market culture that developed was "socially deviant".[13] It is not surprising, therefore, that the extension of this policy and public support for entrepreneurship to the health care sector has been controversial and erratic.

Against this backdrop, health authorities in Zhezkazgan oblast set an ambitious reform agenda to resolve the poor quality and inefficiencies of the health system through the introduction of more market-oriented financing and service delivery. The principal goal was to shift the balance of resources and service provision to primary care through a system of interlocking reforms: 1) rationalization of the hospital sector; 2) introduction of a new incentive-based hospital payment system; 3) reorganization of the primary care delivery system; 4) introduction of new incentive-based payment for primary care; and 5) free choice of primary care providers through open enrollment.

3.1 Restructuring Primary Care

Zhezkazgan health sector leaders made the restructuring of primary care the centerpiece of their health reform agenda. Primary care was physically, financially and administratively separated from the specialist-dominated polyclinic system. Between 1995 and 1997, a network of 89 independent family group practices (FGPs) was established in urban and rural areas throughout the former oblast. Nine new FGPs were established in Zhezkazgan city, all of which were privatized over the period of two years and are now owned by family physicians.[14] Although the primary care practices in Zhezkazgan city are private, they receive nearly all of their financing from government sources through a contract with the Oblast Mandatory Health Insurance (MHI) Fund. As private facilities, the FGPs have greater authority to allocate and manage their resources, set priorities for their services,

[11] Zhezkazgan oblast (with a population of approximately 500,000) was joined with neighboring Karaganda oblast in May 1997 following a presidential decree to reorganize the administrative regions of Kazakhstan. The administrative center of the new oblast is Karaganda city. Following the merger of the oblasts, the health reforms in Zhezkazgan were continued only in Zhezkazgan and Satpayev cities (approximately 60 km apart) and two neighboring rural rayons, with a total population of approximately 300,000.

[12] Kazakhstan was the first republic in the USSR to create its own State Property Committee in January 1991 and began small-scale privatization in August 1991 (Kaser 1997).

[13] Kaser, p. 11-12.

[14] Five of the FGPs began as newly established private facilities. The remaining four FGPs were formerly polyclinics and converted into government-owned FGPs at the beginning of the reform program. After a year and a half operating as government facilities, the FGPs were privatized through a tender process and purchased by the family physicians who were managing them.

and generate and reinvest additional revenue. The government maintains control over quality of care and access to services through the Oblast Health Department's licensing and accreditation program, and a quality assurance system designed and administered by the MHI Fund.

3.2 New Financing Mechanisms

One of the most important results of creating independent primary care entities is that not only can they be financed directly rather than through polyclinics or hospitals, protecting their flow of resources, but also primary care can be paid differently than specialty outpatient care. This introduces new financial incentives that reward increased utilization of primary care, while discouraging excess utilization of specialty care. The change in the organization of primary care service delivery in Zhezkazgan created the organizational structure necessary to implement a capitated payment system. This new payment system accomplishes the dual objectives of shifting government health care resources to primary care, and creating incentives to improve efficiency and quality of primary care services.

Family group practices are now paid a fixed amount each month for each person enrolled in a practice, rather than by a budget based on capacity and the number of visits. Under the new payment system, physicians can now allocate resources in ways they believe are most effective to serve their populations. The FGPs are permitted to retain savings generated by efficiency gains and reinvest them in the practice or pay salary bonuses to staff. In addition, as nongovernmental health facilities, the FGPs have more freedom to reorganize their staffing patterns and other aspects of service delivery to respond to the new economic incentives created by the capitated payment system.

The primary care capitated payment system in Zhezkazgan is a transition to a partial primary care fundholding payment system, in which the capitated payment received by the FGP is increased, and the FGP is responsible for purchasing or providing all outpatient specialty services for its population. The goal is to strengthen the incentives for the FGPs to reduce inappropriate referrals and to invest more of their resources in preventive care and health promotion. It is intended that primary care physicians will have a financial incentive to take on a greater role in managing their patients' health care throughout all levels of the system, thereby increasing the continuity and quality of health care.

3.3 Population Participation

The primary care reforms in Zhezkazgan have been accompanied by an effort to increase the population's involvement through increased information and choice. After the initial stages of the reform process, during which reform goals and approaches were debated and modified, a public information campaign was implemented intensively for several months to introduce the final reform strategy and intended steps to the population. Information was provided to the public by the Oblast Health Department and health providers through the newspaper, television and radio, as well as through special health promotion events.

The first stage of the public information campaign culminated in open enrollment in December 1997, in which the population of Zhezkazgan city was given the opportunity, for the first time ever in Kazakhstan, to choose their primary care provider. More than 75 percent of the population visited the enrollment points throughout the city to actively enroll in the FGP of their choice. In mid-1998, Satpayev city also conducted an open enrollment campaign. These open enrollment campaigns were the first in what will be institutionalized as regular periodic primary care open enrollment in the urban areas of Zhezkazgan.

Under the capitated payment system, FGPs that are able to attract more enrollees also attract a larger share of primary care financing. This incentive to be responsive to the population is expected to provide a counterbalance to the strong efficiency incentives that are being created by the new payment systems.

3.4 Nongovernmental Primary Care Physicians' Association

Finally, early in the reform process, the new family physicians organized themselves into a nongovernmental professional association, which was sanctioned by the Oblast Health Department. The association served to support the practitioners of the FGPs to establish themselves as a new component of the health care system, and to participate in the policy process in an organized manner. The association also assists the FGPs to apply for grants and other sources of joint financing, and may gradually assume some of the government’s role in establishing and enforcing professional standards for primary care providers.

4. Impact of the Health Reform Program on Worker Motivation

4.1 Changes in Organizational Support Systems

4.1.1 Privatization of Primary Care

The most important organizational change in primary health care in Zhezkazgan was the privatization of all primary care practices in urban areas. This bold and controversial step was taken by the Zhezkazgan health authorities because, given the existing legal and regulatory constraints in the public sector, privatization was the most expeditious way to give primary care providers an economic interest in their work. The Zhezkazgan health authorities felt that the opportunity to build a business and reap the financial benefits of serving the population efficiently and effectively should unleash creativity and increase the level of professionalism of primary health care workers.

Economic interest in their work may be the primary source of increased motivation for primary care providers, at least for head physician owner/managers. It is expected that the privatization and the concomitant increase in economic incentives and opportunities will have a direct, positive motivating effect on head physician owner/managers. They now have an opportunity to break free from the rigid salary structure of government polyclinics. In addition, as owners/managers of private enterprises, they have greater opportunity to diversify their sources of revenue, for example, through paid medical and non-medical services. Although their contract with the MHI Fund requires FGPs to provide primary care services free of charge to their enrolled patients, they are permitted to provide enrollees additional discretionary services and care for non-enrolled patients on a fee-for-service basis. Some practices have purchased additional equipment or contracted with specialists to enhance their revenue from fee-for-service patients.

In the context of the former Soviet system, however, not all head physicians will necessarily have the ability or the desire to gain the new skills needed to become effective managers and compete in the more market-driven system. The possibility of a negative effect on the motivation of head doctors from increased economic opportunity gained through competition cannot be discounted. This possibility was articulated by Ryan in the following passage reflecting the sentiments of perestroika-era Soviet Minister of Health Chazov regarding small-scale privatization initiatives in health care:

> That judgment can hardly be discounted as ill-informed or factitious, given the absence of strong entrepreneurial tradition in the Soviet economy and systemic obstructionism, which though diminished could hardly be eliminated with the stroke of a pen. Moreover, to move from the general to the particular, it is necessary to take account of the 'mind-set' of medical personnel who for so many decades have received assured, though low, salaries which were virtually unrelated to their work inputs. The crucial question is: how many will act on the assumption that they can make substantial gain by relinquishing the certainties of bureaucratised medicine for an essentially free market form of practice based on the twin principles of competition and payment according to work input?[15]

[15] Ryan 1990, p. 109.

The privatization of primary care practices has led to a different set of changes in the economic incentives and work environment for health workers other than the head physicians. Since privatization, head physicians have greater control over management decisions, including the organization of staffing patterns and service delivery, and the allocation of financial resources. Head physicians of FGPs now have the authority to change the size and composition of their staffs, hire staff on a contract basis, and supplement salaries with bonus payments related to performance. The head physicians have greater authority to establish their teams, and a wider range of mechanisms to motivate the team members. The extent to which these new incentives, which are essentially new insecurities, for non-owner health care workers constitute a positive source of motivation is largely dependent upon the management skills of the head physicians. The motivational effects on the staff may be driven by financial pressure to perform well and new job insecurity, but a skilled head physician owner/manager will also motivate staff by creating a positive professional atmosphere and the sense of being part of a team with clear values and goals.

4.1.2 New Provider Payment Systems

The introduction of mandatory health insurance in Kazakhstan separated the purchaser from the provider of health care. For the first time, health care is viewed as a commodity, which is a significant departure from the assumptions of the Soviet model. The new payment systems for hospital and ambulatory care that accompanied the introduction of mandatory health insurance treat health services as defined units of output, each with its own cost and value. This concept has had a significant impact on the view of internal resource allocation throughout the health sector in Zhezkazgan.

For example, when a new case-based hospital payment system was introduced by the MHI Fund in Zhezkazgan, the 600-bed oblast hospital conducted an experiment to reduce internal hospital costs and to introduce differentiated salary payment. Each clinical department was given the responsibility to generate its own revenues and to cover its own costs. Building maintenance costs after the introduction of economic incentives were reduced by 63 percent. Salaries of health care workers were differentiated according to performance. Performance criteria included the number and complexity of health services provided, the quality of care, and patient satisfaction. An economic council was established in the hospital, which monitored the business plans of the departments. The head physician and other members of the clinical staff learned to project their costs and revenues and to rationalize expenditures.

In 1996, the MHI Fund began implementing a per capita payment system for primary care. Per capita payment combined with administrative independence, regardless of whether the facility is private, allows the FGPs to reinvest savings they generate through greater efficiency to improve the material base and quality of their practices or provide salary bonuses. These changes provide obvious financial incentives for primary health workers, particularly the head physician owner/managers, to work differently to increase productivity and efficiency.

The new capitated payment system gives the FGPs the incentive and the freedom to set new priorities for the services they provide and be more innovative in how they provide them. FGPs reallocate resources to develop new services and programs that meet the specific needs of their populations, and reorganize their space and schedules to be more comfortable for patients. These new freedoms allow for increased creativity and professional judgment, which may have a motivating effect on all members of the FGP staff independent of the potential financial gain.

The per capita payment system for primary care encourages FGPs to use resources more efficiently to generate savings, but does not provide the incentive to reduce inappropriate referrals or to maintain quality of care and patient satisfaction. In Zhezkazgan, the per capita payment system was intended from the beginning to be a transition to a partial primary care fundholding system. The

fundholding system has not yet been implemented, but FGPs are preparing for this next step and looking for ways to reduce their costs by analyzing their referral patterns, rewarding staff for reducing inappropriate referrals, and expanding the preventive services.

To balance the economic incentives of a per capita and fundholding payment system to reduce referrals, the MHI Fund has also implemented a quality control system. The performance of FGPs is analyzed against a set of quality criteria and indictors, and the practices are penalized financially for poor performance. The most important pressure on quality of care in Zhezkazgan, however, is free choice of primary care provider by the patient through periodic open enrollment. The effect of open enrollment on the motivation of primary health care workers will be discussed in greater detail below.

4.1.3 Level of Financing

The health reform package in Zhezkazgan was designed to shift a greater share of health care resources and service provision to the primary care sector. The Oblast Health Department and the MHI Fund made the decision to reallocate the oblast health care budget administratively toward primary care, even before the new payment systems would accomplish this through market mechanisms. As a result, the share of the government health care budget allocated to primary care in Zhezkazgan has more than tripled since reforms began in 1995, increasing from about ten percent to 36 percent.

The real increase in financing for primary care has been less clear, however, because the overall level of financing for all health care has been variable. When per capita financing was first introduced in 1996, the FGPs received a real increase in financing. For the first time, primary care providers were content with their level of funding and felt they could provide quality services to their populations and improve their personal economic situations. By 1997, all salary debts to health workers were cleared. Since that time, however, financing levels have been inconsistent, and long gaps without financing at all are not unusual. In particular, following the merger of Zhezkazgan with Karaganda oblast, financing for health care in Zhezkazgan has been drastically reduced. The increased economic pressures of incentive-based payment systems make the unreliable financing even more difficult for health care facilities to cope with, which is likely to have a negative effect on health worker motivation.

4.1.4 Open Enrollment

During the open enrollment campaign, FGPs published detailed information for the public on their individual qualifications, philosophies about caring for patients, and even photographs of their provider teams. This created both a new level of accountability to the population, and also a new status for primary care physicians as public figures. Both of these changes may be important in improving primary health worker motivation. Following the information campaign that accompanied the introduction of primary care reforms, patients are more knowledgeable about the health care system in general, and have higher expectations of primary care providers.

Most importantly, both patients and physicians know that if patients are dissatisfied with their primary care provider, they can choose a new one during the next open enrollment, and under a capitated payment system, the money follows the patient. This transfer of some of the power in the doctor-patient relationship to the patient may have an effect on health worker motivation beyond the obvious incentive to attract more patients for financial gain. Open enrollment results are made public, and a practice that does not attract many patients loses not only financing but also professional status among its peers. There is now true competition between primary care providers, both for financing and prestige.

4.2 Worker Experience of Outcomes

The health reforms in Zhezkazgan have increased the clinical role and professional status of primary care providers in the health care system. The government health leadership focused attention and resources on primary care, and the population became more educated about and convinced of the special role that primary care providers play in the health care system. For the first time, primary care is seen to provide the greatest opportunity in the health sector for professional and possibly even financial growth. Some specialists have decided to become retrained as family physicians to share in the new opportunities. In addition, the newly formed family physicians' association, which has links to international organizations and has won grants and received invitations to conferences, has added to the prestige and professional support of primary care practitioners.

The reforms have increased the economic incentive for primary care practices to optimize their utilization of resources, including personnel. To help the practices respond to the new economic incentives and to prepare for fundholding, the FGPs created a new position on their staffs for practice managers.

Primary care practice managers typically have training in economics and accounting, although some unemployed health care workers are beginning to consider the profession of health management. The principal responsibilities of practice managers include completing financial and statistical reports for the MHI Fund and Health Department, establishing organizational policies and procedures within the practice, and participating in planning activities. In addition, practice managers provide internal analysis of resource utilization and the performance of individual health care workers in the practice. For example, each month practice managers provide an analysis of how many patients each physician treated, the number of referrals to specialists and hospitals, the number of ambulance calls, expenditures generated, and other clinical and economic indicators of performance. This information is used by head physicians to evaluate performance, make staffing decisions, and award bonus payments. Practice managers have freed head physicians from many of their administrative and reporting responsibilities, so that the head physicians can spend more time practicing medicine—a more rational use of resources. The participation of head physicians in clinical work may be more motivating for the physicians themselves, as well as the rest of the staff.

The internal analysis of performance creates some peer pressure and competition within the primary care staff that is likely to have a strong effect on motivation and the desire to perform well. Most importantly, the head physicians of FGPs now have the authority to fire staff who are not performing effectively. Health workers are aware of the oversupply of medical personnel and know that job loss is a real threat. The availability of quantitative data to support the evaluation and dismissal of health care workers in the practice, however, possibly makes the process more objective and fair, and therefore more easily accepted.

The MHI Fund has also implemented a computerized health information system, which is used for both new provider payment and quality control systems. The MHI Fund provides non-threatening, constructive feedback to the FGPs on their performance. In Zhezkazgan, the MHI Fund works with FGPs as colleagues and collaborators to improve the quality of health care services. This collaborative relationship between FGPs and the MHI Fund increases the professional autonomy and status of the primary care providers, and may contribute positively to their level of motivation to implement the reforms. Such a cooperative relationship between a government control body and health care workers continues to be unusual in regions where reforms have not yet matured.

4.3 Worker Capability

The health reforms have made clinical, as well as economic and management, knowledge and skills increasingly important. Health workers are hired and retained on a competitive basis, and, therefore, professional qualifications and achievements are more valuable. In addition, open enrollment has made the professional qualifications of each FGP public information, increasing the pressure on FGPs to maintain a highly qualified and skilled staff.

At the beginning of the reform process, the disadvantaged position of primary care physicians was addressed directly by the Oblast Health Department. As more resources and service delivery were shifted to the primary care sector, the clinical capability of the FGPs was also increased through clinical training and improved equipment. The local government actively supported the health reform program, and the oblast administration allocated supplemental resources to the health budget to finance the development of primary care. Training and equipment were financed by savings generated by rationalization of the outpatient specialty and hospital sectors, grants from international organizations, and partially by physicians themselves.

Clinical training of primary care workers was one of the central components of the reforms. An initial survey of the population revealed that the main concern people have about their primary care is the technical ability of the practitioners. Historically, the best physicians have practiced in hospitals, which is one of the reasons patients often bypass the primary care system and go directly to hospitals.

Aside from raising the general clinical competence of primary care physicians, an important aspect of training changed many specialists into general or family practitioners. Because family medicine is a new field in Kazakhstan's health care system, FGPs began as groups of therapists, pediatricians and gynecologists who are gradually being retrained as family physicians. These physicians, in addition to their previous specialty training, completed an intensive two-month course in general medicine and family practice. After completing the family practice training course, the members of the group began cross-training in the FGP to gain the necessary knowledge and skills to provide care to patients outside of their specialty. This cross-training not only serves to broaden the skills of new family physicians, but also helps to establish the spirit of a professional team within the practice. Additional training has also been provided for new family doctors in specific topic areas, such as infectious diseases and family planning, so FGPs can expand their scope of services and incorporate traditionally vertically-provided services into the primary care package.

The FGP practitioners have also expanded their knowledge and skills by participating in numerous conferences and seminars about all aspects of health reform, particularly new finance and management methodologies. In addition, many primary care physicians have chosen to enroll in courses in economics and finance at their own expense. The clinical training, as well as the finance and economics training, have not only increased the skill level of the primary health care workers, but has also helped them to carve out a new role for themselves in the health care system. Rather than being considered weak specialists, these physicians are now considered to be a new kind of health care provider with unique training and skills. Having a clearly defined role in the system and being adequately trained to fill that role is likely to have strong motivational effects on primary care physicians.

5. Communication Between Ministry of Health and Health Workers about the Reform Program

In Kazakhstan, local governments have significant power in the health sector. Therefore, in oblasts with progressive leadership, such as Zhezkazgan, health reform has moved much more quickly than at the national level. The Ministry of Health (MOH) has supported the Zhezkazgan reform movement in principle, but showed resistance to some individual activities, including rationalization and closure of health facilities and privatization. National-level decrees often posed obstacles to local reform efforts, and the MOH was reluctant to update or abolish them. Zhezkazgan oblast obtained special status as a health reform demonstration site, which allowed the oblast to waive certain national level regulations and in general move reforms at a faster pace than the national MOH would have accepted.

For example, Zhezkazgan had one of the first private health care facilities in the Commonwealth of Independent States (CIS) to work under contract with a government financing agency (the MHI Fund). National government authorities, including the MOH, the sanitary-epidemiological service, and the tax authorities intensely scrutinized the work of the clinic and repeatedly examined its activities and records. The authorities eventually became convinced of the validity of this uncommon relationship between the public and private sectors. Now there are more than 1,200 such health facilities in Kazakhstan.

In Zhezkazgan, the oblast health leadership implemented reforms in such a way that health workers trusted both the motives and the process. The leadership style was a combination of participatory and autocratic decisionmaking, which was successful in the local context. Health professionals felt that they were included in the process, but were also comfortable that the leadership was strong and willing to take ultimate responsibility for the process and the outcomes.

Health workers' understanding of the reforms was a crucial element in the successful implementation. Involvement of primary care physicians in discussions of health sector restructuring was a completely new approach to policy development and decisionmaking. The head of the Oblast Health Department openly discussed policy changes and their implications with health workers, and held seminars to explain the goals of reforms with objective economic arguments. The family physicians' association was particularly active in policy discussions. The Health Department also had a close and productive relationship with local mass media, so each step of the health reform process was communicated and explained to both health workers and the population.

The vision of where the reforms were going was clear to health workers, and most importantly, they trusted that policy changes would be implemented. Due to the credibility of the leadership, new policies began to have an impact on the behavior of health workers even before they were implemented. For example, all primary care physicians knew that eventually there would be open enrollment, and started marketing themselves to patients well before open enrollment was implemented. In addition, the FGPs knew they would be responsible for fundholding, and started analyzing their data, changing their behavior, and improving their services well in advance of the implementation of fundholding. This response has made the implementation of reforms proceed more smoothly and evenly, further reinforcing effect on the credibility of the leadership and the belief in the reform process among health care workers.

Zhezkazgan's health sector leadership made many politically difficult and unpopular decisions in order to rationalize the health sector and create a new system of primary care under severe budgetary constraints. Specialty facilities were closed and personnel positions reduced. To reduce political opposition, the Health Department tried to reduce costs in uncontroversial ways, and minimize the number of people left unemployed by the reforms. Fixed costs were reduced by closing buildings and installing meters to reduce expenditures on utilities. The number of staff positions in the health sector were reduced, but the number of people employed did not change significantly, because many health workers were previously assigned to more than one position to supplement their salaries. When personnel were actually reduced, health workers were often reassigned to other health facilities. Therefore, the opposition to the reforms in Zhezkazgan, though often vehement at the national level, never became a serious threat from health workers in the oblast. Some of the most difficult rationalization of the health sector in Zhezkazgan may still lie ahead.

6. Assessing the Impact of Reforms on Health Worker Behavior and Motivation

In Zhezkazgan, there is evidence that there has been an overall positive effect of the health care reform package on primary health worker motivation. There seems to be an increased level of commitment and professionalism among primary care providers, and there have been observable changes in aggregate primary care sector performance that could not occur without motivated health care workers. Since the reforms began, there have been many innovations in primary care service delivery to improve quality of care and convenience for patients. In addition, the FGPs are providing services that are not required by their contracts, and that do not directly generate additional revenue.

6.1 Impact on Head Physician Owner/Managers

The new professional status and autonomy that primary care providers have gained from becoming independent of higher level health care facilities, and later being privatized, has been an important source of motivation, particularly for the physician owner/managers. Although it was difficult and risky to start a new business, physicians believed that if they work harder today they will be better off tomorrow. Primary care physicians who became private owners of their practices in Zhezkazgan saw this new opportunity as a way to take control of their future, which they could not do under the former system. Purchasing a FGP was a source of economic and professional opportunity and a symbol of prestige among physicians, primary care physicians and specialists alike. Several physicians made great personal and financial sacrifices to embark on this new venture, selling personal assets, such as automobiles and land to obtain the capital to purchase a FGP.

Primary care physicians in Zhezkazgan who own their own practices now have the opportunity to improve both their financial and professional status by working harder, being innovative, and being more responsive to the needs and demands of their patients. There is a new sense of pride in the appearance of the health facilities and the health workers themselves. The FGPs have all been remodeled, and head doctors have used their own resources to paint the rooms, hang curtains and install carpets. Many head physicians have brought furniture and other items from home to improve the appearance and comfort of the practices. In addition, most FPGs in Zhezkazgan have expanded their hours of operation beyond what is required by their contract for government financing, and physicians make themselves accessible to their patients twenty-four hours a day. There is no direct financial incentive to do this under a capitated payment system, which pays the same each month for a patient regardless of the number of visits or the cost of the services provided.

One head physician of a FGP uses his personal automobile to make home visits and transport elderly and disabled patients to referral appointments. A head physician of one FGP used her own resources to provide free meals for children that came to her practice to receive treatment in daybeds. Another FGP organized a laboratory in the practice so patients would not have to go to a different location for tests, although the FGP does not yet receive additional payment from the MHI Fund for laboratory services. One FGP, owned by a family physician who was originally trained as a cardiologist, has established a “cardiology club” for patients suffering from heart disease. This club supports patients to make lifestyle changes to prevent further cardiovascular illness. A cardiologist and a nurse work with the group to advise them free of charge on how to improve their dietary patterns and other risk factors for cardiovascular disease.

The cardiology club also demonstrates the new understanding and acceptance among primary care practitioners of patient involvement and control over their own health care, which was uncommon under the former health care system. At the founding conference, the cardiology club members elected their chairman, a patient-leader who had had a heart attack and who now sets an example for other members by his healthier lifestyle. The club meets on a monthly basis, and club members are provided with training, written information and videos on how to reduce risk factors, self-treatment, and recognizing symptoms that require emergency treatment. The hospital admission rate for club members has decreased from 49 percent to 28 percent, the readmission rate decreased from 6 percent to 5 percent, and ambulance calls were decreased by 1.5 times.

The FGP owners have become motivated to operate more like businesses, and use resources more rationally. Some FGP owners have opened non-medical enterprises to utilize excess space and subsidize their primary care practices. One FGP opened a hairdresser, a shoe repair shop, and a contact lens office in unused rooms of the practice. These for-profit services offset some of the costs of the FGP space, provide revenue that can subsidize the operation of the practice, and offer convenient non-medical services to patients.

6.2 Impacts on Other Members of the FGP Staff

The motivational effects of reforms on health workers other than the head physicians are less clearly observable. Head physicians report anecdotally, however, that hiring staff on a contractual basis, with compensation and continued employment linked to performance, has improved the overall level of motivation and performance of health workers on their staffs. A primary source of motivation is the internal competition between health workers in a practice that is created by the objective analysis of performance provided by practice managers, and the awarding of bonus payments to the best performing staff members.

In addition, the opportunity for the head physician to create a work environment and culture that reflects his or her values and goals has had a motivating effect on the rest of the staff. Some FGPs plan regular social activities to unite the staff personally as well as professionally. Several of the FGPs engage in marketing activities that have created distinct images for the practices. For example, they have created uniforms and logos to generate a professional image and a team spirit in their practices. As a result, it has become prestigious to work in some of the FGPs. For example, one FGP head doctor said, “Our employees proudly say: ‘We work in the clinic ‘Zhurek’!”

The health reform package in Zhezkazgan has emphasized expanding the role of primary care physicians in health care system, but the role of other primary care providers, particularly nurses, has been less prominent. It is unlikely that nurses have experienced much change in their clinical role, professional autonomy, or compensation. In order to realize the full effects of increased health worker motivation, the entire provider team must face new incentives, opportunities and professional status.

6.3 Impact on Health Worker Motivation in Other Reform Sites in Kazakhstan

In other sites of the country, where only some aspects of the Zhezkazgan health reform package have been implemented, there have not been clearly observed effects on health worker motivation. This has been particularly true in rural areas. In the rural areas of the former Zhezkazgan and Semipalatinsk oblasts, primary care clinics (SVAs) have been made administratively and financially independent of central rayon hospitals and receive per capita payment. In these rural areas, however, the primary care practices have not been privatized, nor is there effective free choice of primary care provider because of the sparse population density and vast distances between SVAs.

In these rural areas there has been some evidence of innovation and motivation to improve efficiency and reduce expenditures, but there is not the clear change in the overall level of motivation of health workers that is observed in the urban areas of Zhezkazgan. Without effective competition, a direct link between performance and financing, and increased accountability to the population through open enrollment, the economic and other incentives to be more responsive to patients are significantly reduced. In addition, the rural primary health care workers are isolated and operate with very little professional support, and they are often both physically and psychologically distant from the health policy process.

Currently, in Semipalatinsk city, the urban primary care financing and delivery systems are being restructured according to a model that is similar to that being implemented in Zhezkazgan and Satpayev cities. All of the practices will receive administrative and financial independence with increased management autonomy, and there will be per capita payment, salary bonus systems, and open enrollment. Only a small number of practices will be private, however, with most of the physicians remaining as salaried government employees. In the context of the Semipalatinsk reforms, there will be an opportunity to study the effect of privatization versus management autonomy in a public facility on creating the incentives and professional environment that lead to improve the level of motivation of primary health care workers.

7. Conclusions

The health reforms in Zhezkazgan were not designed with the explicit goal of increasing health worker motivation. The change in the overall organizational relationships and economic incentives in the health sector, however, clearly have had an impact on motivation through changes in the utilization of human resources, the level and form of compensation of health care workers, and job security in the health sector. There is now effective competition between primary care practices, and increased competition between health workers within the practices. Performance of health workers is evaluated more effectively and objectively with the help of new information systems and practice managers, and compensation and continued employment are directly linked to performance.

The changes in the economic incentives, however, are not the only channel, or perhaps not even the most important channel, through which health worker motivation has been affected. During the implementation of reforms, financing for health care has been inadequate and irregular, with long gaps without any financing at all in Zhezkazgan. There were many months in which primary health care workers did not receive their salaries. Nonetheless, there appear to have been positive effects on primary health worker motivation and performance.

Equally important, therefore, may be the change in the level of professional status and autonomy that primary care practitioners have gained from the reforms. There is a new more professional work environment and defined culture within the primary care facilities. Furthermore, the evaluation of the performance of practices and individual providers has been made public through new health information systems, published open enrollment results, and FGP association activities. The increased visibility of performance and the accompanying peer pressure may have had effects on health worker motivation independent of financial incentives.

Also important is the new relationship with and level of accountability of primary care providers to the population. Open enrollment has made the FGPs learn more about their populations, what their health problems are and what they want and expect from their primary health care providers. Working as true family practitioners with a defined role in the health system and the communities they serve may have given the primary health workers a greater interest in their patients and increased motivation to serve them well.

Finally, the process of policy change was participatory. Health workers were kept informed about and were involved in the development of new policies. It is possible that primary care providers feel ownership of the reform process and therefore feel responsible to do their part to ensure that the reforms are successful.

As discussed above, however, because of the historical and cultural context shaped by the former Soviet system, the apparent positive Zhezkazgan experience may be neither universal in Zhezkazgan nor generalizable to other areas of Kazakhstan or the CIS. The lack of a market culture or management skills in medicine under the former Soviet system make it unlikely that all or even most health care workers are willing and able to respond positively to the new opportunities and competitive pressures in the system. Those physicians who joined the first wave of reforms are likely to have been the most entrepreneurial and the least risk-averse. More experience and evaluation is needed, therefore, to truly understand whether or which aspects of the Zhezkazgan primary health care reform model will lead to sustainable improvements in the motivation and performance of health care workers, and ultimately in the health of the population.

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